



HOUSTON INDEPENDENT SCHOOL DISTRICT

School Vision Screen Report

ATTENTION PARENT: As part of the School Health Program the state requires students in identified grades be screened according to schedule. The information below indicates that your child **failed the school vision screen** and needs to be examined further by an eye doctor.

Student Name _____ Birthdate _____ Age _____ Gender _____
 School _____ Teacher _____ Grade _____
 Parent or Guardian _____ Phone (____) _____

VISION SCREENER REPORT		
DISTANCE ACUITY SCREEN:		
Referral to a primary care provider due to the following:		
Results Date _____ Failed the following vision test(s): <input type="checkbox"/> Distance Acuity Test <input type="checkbox"/> Light Reflex Test <input type="checkbox"/> Near Vision Test With Correction: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Observable Signs or Symptoms/ Comments: _____ _____ _____ _____	<input type="checkbox"/> Other: _____ _____ _____ _____ <input type="checkbox"/> UNABLE TO SCREEN
Chart Used and results for each eye: Letter <input type="checkbox"/> Rt Eye 20/____ <input type="checkbox"/> Lft Eye 20/____ "E" <input type="checkbox"/> Rt Eye 20/____ <input type="checkbox"/> Lft Eye 20/____ HOTV <input type="checkbox"/> Rt Eye 20/____ <input type="checkbox"/> Lft Eye 20/____		Comments/ Observations:
Light Reflection Test		
HIRSCHBERG CORNEAL or COVER AND UNCOVER <input type="checkbox"/> PASS <input type="checkbox"/> FAIL <input type="checkbox"/> N/A	NEAR: 12 to 13 inches <input type="checkbox"/> PASS <input type="checkbox"/> FAIL <input type="checkbox"/> N/A	FAR: 10 to 20 feet <input type="checkbox"/> PASS <input type="checkbox"/> FAIL <input type="checkbox"/> N/A
School Nurse (please print):		Phone Number:
Signature of School Nurse:		Date:

*** WAIVER OF REFERRAL ***

My child _____ is being seen by an eye care specialist,
 _____ (doctor's name), for the problem(s) indicated.

Parent's Signature _____ Date _____

Eye Examination Report

To Be Completed By Examining Physician

Student Name _____ Birthdate _____ Age _____ Gender _____ Grade _____

Case History Date of exam _____

Ocular history: _____ Normal or Positive for _____

Medical history: _____ Normal or Positive for _____

Drug allergies: _____ NKDA or Allergic to _____

Other Information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? _____ Yes _____ No

	Normal	Abnormal	Unable to Assess	Comments
External exam (lids, lashes, cornea, etc.)				
Internal exam (vitreous, lens, fundus, etc.)				
Internal exam (vitreous, lens, fundus, etc.)				
Pupillary reflex (pupils)				
Binocular function (stereopsis)				
Accommodation and vergence				
Color vision				
Glaucoma evaluation				
Oculomotor assessment				
Other				

Diagnosis: _____ Normal _____ Myopia _____ Hyperopia _____ Astigmatism _____ Strabismus _____ Amblyopia

Other _____

Recommendations

1. Corrective lenses: _____ No _____ Yes, glasses or contacts should be worn for:

_____ Constant wear _____ Near vision _____ Far vision _____ May be removed for physical education

2. Preferential seating recommended: _____ No _____ Yes

Comments _____

3. Recommend re-examination: _____ 3 months _____ 6 months _____ 12 months _____ Other _____

Print name _____ Signature _____ Date _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination _____ MD _____ OD _____ DO

Address _____ Phone (_____) _____



DISTRITO ESCOLAR INDEPENDIENTE DE HOUSTON

Reporte del examen de la vista en la escuela

ATENCIÓN PADRES: Como parte del Programa de Salud Escolar, el estado requiere que los estudiantes de ciertos grados hagan un examen de acuerdo al programa. La siguiente información indica que su hijo **no pasó el examen de la vista en la escuela** y necesitará un examen más a fondo por un doctor de ojos.

Nombre estudiante _____ Fecha nac. _____ Edad _____ Género _____
Escuela _____ Maestro _____ Grado _____
Padre o tutor _____ Tel. (_____) _____

** REPORTE DEL EXAMEN DE LA VISTA **

Prueba de agudeza visual a distancia:

Se hace la referencia con un especialista debido a lo siguiente:

Resultados Fecha _____ Falló la siguiente prueba(s) de visión: <input type="checkbox"/> Examen de agudeza a distancia <input type="checkbox"/> Examen de reflejo de luz <input type="checkbox"/> Examen de visión de cerca Con corrección: <input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Signos o síntomas observables Comentarios: _____ _____ _____ _____	<input type="checkbox"/> Otro: _____ _____ _____ _____ <input type="checkbox"/> NO SE PUDO EVALUAR
Gráficas y resultados de cada ojo: Letra <input type="checkbox"/> Ojo der 20/____ <input type="checkbox"/> Ojo izq. 20/____ “E” <input type="checkbox"/> Ojo der 20/____ <input type="checkbox"/> Ojo izq. 20/____ HOTV <input type="checkbox"/> Ojo der 20/____ <input type="checkbox"/> Ojo izq. 20/____		Comentarios/ Observaciones: _____ _____ _____ _____
Examen de reflexión de luz REFLEJO CORNEAL (Hirschberg) o CUBIERTO Y DESCUBIERTO <input type="checkbox"/> PASÓ <input type="checkbox"/> FALLÓ <input type="checkbox"/> N/A	CERCA: 12 a 13 pulgadas <input type="checkbox"/> PASÓ <input type="checkbox"/> FALLÓ <input type="checkbox"/> N/A	LEJOS: 10 a 20 pies <input type="checkbox"/> PASÓ <input type="checkbox"/> FALLÓ <input type="checkbox"/> N/A
Enfermera escolar (anotar nombre): _____ Firma: _____		Teléfono: _____ Fecha: _____

*** EXENCIÓN VOLUNTARIA DE REMISION ***

Mi hijo _____ está siendo visto por un especialista de ojos,
_____ (nombre del doctor), por el problema(s) indicado.

Firma del padre _____ Fecha _____

Eye Examination Report

To Be Completed By Examining Physician

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Medical history: _____ Normal or Positive for _____

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Other Information _____

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Color vision				
Glaucoma evaluation				
Oculomotor assessment				
Other				

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